American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:	
	AAA Case No.
	AAA Assessment No.
- and -	Applicant's File No.
Met Life Auto & Home Insurance Co.	
(Respondent)	Insurer's Claim File No.

ARBITRATION AWARD

I, Marilyn Felenstein, Esq., the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as:Assignor

1. Hearing(s) held on
☒09/19/12
and declared closed by the arbitrator on 9/19/12.

Naomi Cohn Esq. for Gene Sigalov Esq. participated in person for the Applicant.
Richard Aiken Esq. for Bruno Gerbino participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$4,297.95**, was
AMENDED and permitted by the arbitrator at the oral hearing. (Amendments, if any, set forth below).

The amount in dispute was amended to be $2939.80.

STIPULATIONS were not made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Was the denial based on the peer review by Dr. Thomas proper?

4. Findings, Conclusions, and Basis Therefor

The Arbitrator has considered all of the documentation submitted by the parties to the American Arbitration Association electronic case folder (ECF) as of the date of the hearing as well as the oral arguments of the parties and the testimony of Karen Thomas, D.C.

Applicant submitted this claim for manipulation under anesthesia (MUA) performed Applicant for Assignor on May 3, 4 and 5, 2011. Respondent denied the claim in a timely manner based on the peer review of Dr. Karen Thomas who concluded that there was no medical necessity for the procedures.

A provider establishes a prima facie case of entitlement to reimbursement by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no-fault benefits was overdue. *See Insurance law sec. 5106; Mary Immaculate Hosp. v. Allstate Insurance Co,* 5 AD3d 742, 77 N.Y.S.2d 56 (2004). A properly completed claim form, which suffices on its face to establish the particulars of the nature and extent of the injuries and health benefits received and contemplated and proof and fact of the loss sustained is all that is needed at the claim stage to establish the health benefits medical necessity. *Amaze Medical Supply v. Eagle Insurance.* 2 Misc. 3d 128 (A). Applicant herein has met that burden.

Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins Law sec. 5101, an insurance carrier is obligated to reimburse an injured party (or his or her assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. Proof that the benefits were "medically necessary" is not an element of the prima facie case.

The defense that the benefits were not "medically necessary" is an affirmative defense to be proven by the insurer. Once Applicant has established a prima facie case, Respondent must prove that the treating doctor's services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment such as by a qualified expert performing an independent medical examination or by a peer review report which is a medical professional's written evaluation of the medical necessity of the services provided. The peer reviewer report must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. Vladimir Zlatnck, M.D. P.C. v. Travelers Indem. Co, 2006 NY Slip Op 50963(U) (App. Term 1st Dept., 2006), *Contempo Med. Care PV v. Travelers,* 2006 Slip Op 51338U, 2006 NY Misc. LEXIS 1815; *Amaze Med. Supply v Eagle Ins Co.,* 2 Misc3d 128[A], 2003 NY Slip Op 51701[U] [App. Term 2d and 11th Jud Dists 2003]; *S & M Supply v Kemper Auto Home Ins. Co.,* 2 Misc3d 14[A], 2004 NY Slip Op 50209[U] [App Term, 2d & 11th Jud Dsts 2004]

Dr. Thomas appeared at the hearing and testified in regard to her peer review. In addition to considering all of the medical records provided, she relied largely on her own examination of Assignor on March 31, 2011. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App. Div. 2d Dept. Jn. 20, 2009); *Channel Chiropractic P.C. v. Country-wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3 294 (1st Dept 2007); *Bronx Radiology P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App. Term 1st Dept 2007), such as by an independent medical examination, conducting a peer review of the injured person's treatment or reconstructing the accident.

An insurance carrier may utilize an independent medical examination (IME) to determine whether an eligible injured person is entitled to further care and treatment or other first-party

benefits. *Rowe v. Wahnow*, 26 Misc.3d 8, 11 – 12 (App. Term, 1st Dept. 2009). However, an IME is only a snapshot of the injured party's medical condition as of the date of the examination. *Amato v. State Farm Ins. Co.*, 2010 N.Y. Slip Op 20431 (Dist. Ct. Nassau Co.)

An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. *Ying E. Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), 2008 N.Y.Slip Op 51863(U) (App. Term 2d & 11th Dts. Sept. 2008) If the report is conclusory in nature and lacking a detailed basis and medical rationale for the denial of benefits, it is clearly insufficient to sustain Respondent's position.

The determination that an eligible injured person no longer needs treatment is generally based upon an examiner's findings that result in the conclusion that: (1) the EIP has fully recovered from the injuries; (2) the EIP has made as full a recovery as is possible taking into account the nature and extent of the injuries, the EIP's age, pre-existing conditions or other factors; and/or (3) additional treatment or testing will not provide any medical benefits to the EIP. *Amato v. State Farm Ins. Co.*, 2010 NY Slip Op 20431 (Dist. Ct. Co., Oct. 13, 2010)

The opinion of the insurer's expert, standing alone, is insufficient to meet the insurer's burden of proving that the services were not "medically necessary". *CityWide Social Work & Psychological Servs. V. Travelers Indem. Co.* , 3 Misc3d 608 [Civ Ct. Kings County]; *Ultimate Med. Supplies v. Lancer Ins Co.,*7 Misc3d 1002[] [Civ.Ct. Kings Co. 2004. At a minimum, the insurer should establish a factual basis and medical rationale for the lack of medical necessity determination. Generally accepted medical practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling.

Dr. Thomas appeared at the hearing and testified. She noted that she had examined Assignor on March 3, 2011, two months prior to the MUAs in dispute. At that time Assignor complained of radiating neck pain and right side lower back pain. She concluded that the Assignor's subjective complaints did not support the objective findings made by Dr. Thomas. She concluded that Assignor's symptoms were indicative of all soft tissue injuries which were now resolved. Dr. Thomas also made reference to the report of a consultation by Apex Medical on April 6, 2011. That report indicated that Assignor demonstrated improvement though decreased sensory response and deep tendon reflexes were present.

Dr. Thomas testified that there was no evidence of injury that would have required MUA. She found no evidence of disc injury or evidence of contracture or intractable pain. There was also no evidence that the Assignor could not tolerate regular chiropractic treatment. Dr. Thomas refers to the guidelines of the National Academy of MUA Physicians which would indicate that MUA would be appropriate when the pain threshold inhibits the efficient use of conservative manipulation or when muscle contraction of prolonged period state is demonstrated despite treatment. The procedure, according to Dr. Thomas would also be considered if the patient failed in consterva tive chiropractic or if thepatient is in too much pain for adjustment to be done in the office.

According to Dr. Thomas, Assignor herein did not meet any of those criteria. There was no evidence of disc syndrome or positive neurological signs or nerve injury. She discusses at length the lack of sclerotogenous pain or evidence of adhesive capsulitis or paravertebral muscle contracture. According to Dr. Thomas, based on her examination of the Assignor he

had benefitted from the conservative chiropractic treatment being provided and there was no need for the MUA.

It is the determination of the Arbitrator that the peer review, supported by her testimony, establishes a rational and reasonable basis for the position that the MUA was not medically practices. Once the peer review sets forth a reasonable factual basis and medical rationale for the opinion regarding the medical necessity for the treatment in dispute, the trier-of-fact will look to the Applicant to rebut the evidence and conclusion reached by the peer reviewer. In the absence of such a rebuttal, the denial of the claim can be sustained. A. Khodadadi Radiology, P.C. v. N.Y. Centr. Mut. Fire Ins. Co., 16 Misc.3d 131[A], 2007 NYS Slip Op 51342[U] [App. Term 2d & 11th Jud Dsts 2007]

Dr. Thomas was cross-examined at great length by counsel for Applicant. She conceded that the guidelines that she relied on had changed since her peer review was prepared. She was unclear as to exactly what the changes were and could not definitively state that her opinion and conclusion were in keeping with the current standards.

Based on the cross-examination of Dr. Thomas and the medical records submitted, the Arbitrator determines that the peer review does not withstand scrutiny and cannot be used as a basis for the denial of this claim. Award in favor of Applicant.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	2,939.80	2,939.80
Totals:	$2,939.80	$2,939.80

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 03/29/2012, which is a relevant date only to the extent set forth below.)

Where a claim is timely denied, interest shall begin to accrue as of the date adjudication is commenced by the claimant, i.e. the date the claim is received by the American Arbitration Association, unless arbitration is commenced with 30 days after

receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 11 NYCRR 65-3.9©; LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co., ____A.D.3d ___, ___N.Y.S.2d ____, 2007 WL 4531300 (3d Dept. Dec. 27, 2007); Hempstead General Hosp. v. Insurance Co. of North America, 208 A.D.2d 501, 617 N.Y.s.2d 478 (2nd Dept. 1994); Smithtown General Hosp. v. State Farm Mut. Auto. Ins.Co., 207 A.D.,2d 38, 615 N.Y.S.2d 426 (2nd Dept. 1994). The end date for the calculation of the period of interest shall be the date of payment of the claim.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below.

The Respondent shall also pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e). Attorneys' fees are to be calculated based on the aggregate of all bills for each insured. Payment shall be made of 20% of the amount of first party benefits plus interest thereon awarded by this Arbitrator subject to a maximum of $850.00 pursuant to 11 NYCRR 65-4.6(e).

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of New York.

I, Marilyn Felenstein, Esq., do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

Marilyn Felenstein

10/18/12
(Dated)

(Marilyn Felenstein, Esq.)

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.